PACIFIC INFUSION CENTER
Friendly • Experienced • Caring

5230 Pacific Concourse Dr. Ste 100
Los Angeles, CA 90045
www.pacificinfusion.com
(310) 297-9269 office
(310) 297-9222 fax

Patient Name: _____ Phone:_____

Physician use only:

DOB: _____Patient Weight (in kg): _____

SIG:

† ☐ **Abatacept** _____mgs IV on weeks 0, 2, 4 and then every 4 weeks
† ☐ **Belimumab** 10 mgs per kg IV on weeks 0, 2, 4 and then every 4 weeks
† ☐ **Certolizumab Pegol** _____mg SC on weeks 0, 2, 4 and then every 4 weeks
† ☐ **Denosumab** 60 mg SC every 6 months
† ☐ **Golimumab** 2 mgs per kg IV at weeks 0, 4 and then every 8 weeks
† ☐ **Ibandronate** _____mg IV
† ☐ **Infliximab** _____mgs per kg IV @ weeks 0, 2, 6 and then every ___weeks
† ☐ **Ocrelizumab** _____300 mgs IV @ weeks 0, 2 and then 600mg IV every 6 months
† ☐ **Rituximab** _____ mgs IV every _____
† ☐ **Tocilizumab** _____mg IV every 4 weeks
† ☐ **Ustekinumab** _____mgs IV @ weeks 0, 4 and then _____ mg IV every ____ weeks
† ☐ **Vedolizumab** _____mgs per kg IV @ weeks 0, 2, 6 and then every ___weeks
† ☐ **Other:** _____† IM or† IV q _____

Premedication?: ☐ **Yes** ☐ **No**

† ☐ **Acetaminophen** _____mg PO
† ☐ **Diphenhydramine** 25mg IV
† ☐ **Fexofenadine** 180mg PO
† ☐ **Methyprednisolone** 40mg IV
† ☐ _____

☐ **Screening labs/tests sent to us**

Dx: _____ ICD-10 code:_____

MD Signature: _____ Date: _____

Fax this prescription to our office with facesheet/insurance card/requested labs and/or tests (see www.pacificinfusion.com for comprehensive list) & give copy to patient.